MediCross Accident & Medical Clinic
8 Egmont Street | New Plymouth 4310
admin@medicross.co.nz
Ph 06 759 8915
Fax 06 759 8917

I M P O R T A N T - It is preferable that your Travel Consultation appointment is made one month prior to your departure. Please return this record this form promptly. You will be advised of an appointment time and date.

P L E A S E N O T E - There will be a charge for each person for an extended consultation, even if your travel has been discussed previously with your own GP.

TRAVELLER'S MEDICAL RECORD

DATE _____

FIRST NAME _____**SURNAME** _____

ADDRESS _____

_____ POST CODE _____

DATE OF BIRTH _____ Ethnicity _____

TELEPHONE _____ MOBILE PHONE _____

I (FULL NAME)_____ hereby consent to the administration to myself of the vaccines as listed below.

YOUR HEALTH

1. **Have you travelled to less developed countries before?**
   ☐ **Yes** ☐ **No**

   Did you have any health problems while away?
   ☐ **Yes** ☐ **No**
   If yes, please specify.....

2. **Do you have or have you ever had any medical problems?** eg, asthma, chronic bronchitis, diabetes, stomach ulcer, splenectomy, epilepsy, heart disease, depression, schizophrenia, anxiety attacks, mental illness, weakness of immune system, HIV/AIDS, blood clots
   ☐ **Yes** ☐ **No**

   If yes, please specify.....

3. **Have you been in hospital in the last year?** ☐ **Yes** ☐ **No**
4. **Have you had a blood transfusion?** ☐ **Yes** ☐ **No**
5. **Have you ever had hepatitis?** ☐ **Yes** ☐ **No**
6. **Are you taking any medication now?** eg: contraceptive pill, antibiotics or do you occasionally take medication? eg: migraine tablets, ventolin, vitamins
   ☐ **Yes** ☐ **No**

   If yes, please specify.....

7. **Do you have any known allergies?** eg: sulphur drugs, eggs, nuts, penicillin, bee stings, iodine, neomycin, latex, band aids? Y

☐ **Yes** ☐ **No**

If yes, please specify.....

8. **Women only: Are you pregnant or is it a possibility on your return?**

☐ **Yes** ☐ **No**

9. **Please list any past vaccinations and date/year of administration**:

BCG	Diphtheria/Tetanus	Typhoid
Hep A	Hep B	Meningitis
Influenza	MMR	Rabies
Polio	Yellow Fever	

Other.....

10. **Do you have any particular health concerns regarding this trip?**

☐ **Yes** ☐ **No**

Please outline .....

YOUR TRIP

11. **Please list in order the countries you intend visiting, and how long you plan to spend in each**:

....days

....days

....days

....days

....days

....days

....days

12. **What is the main purpose of your trip?** (Please circle)

☐ Holiday ☐ Visiting family/friends ☐ Business Trip

☐ Other _____

13. **Type of Accommodation?** (Please tick)

☐ Camping ☐ Budget ☐ Air Conditioned Hotel ☐ Private ☐ Home

☐ Other _____

14. **Planned activities?** (Please tick)

☐ Trekking / Altitude ☐ Scuba Diving ☐ Cycling ☐ Rafting / Boating

☐ Other _____

15. **Date leaving New Zealand** _____

Date returning to New Zealand _____

PRE-TRAVEL WORKSHEET
(to be completed by Medical Staff)

Vaccine	Number of Doses Required
☐ Hepatitis A	One injection, booster at 12 months will provide immunity up to 10 years
☐ Hepatitis A & B	Course of three injections. 0, 1 and 6 months.
☐ Hepatitis B	Course of three injections one month apart. Life long immunity.
☐ Japanese Encephalitis	Two injections. 1, 28 days after first injection
☐ Meningococcal ACYW	One injection. Booster at 2-3 years.
☐ Polio	One injection if had childhood immunisation. Booster every 10 years.
☐ Rabies	Three injections. 0, 7, 28 days. Booster at one year.
☐ Tetanus (ITETNS)	Give one injection if more than 10 years since previous booster dose.
☐ Typhoid	One injection. Three yearly booster.
☐ Hepatitis A / Typhoid	Booster six months. Revaccinate against Typhoid every three years.
☐ Cholera	Two injections. 1 and within 6 weeks.

Recommended Vaccinations [Please tick the vaccinations you wish to have and total the cost]

.....	$	.....	$.....
.....	$	.....	$.....
.....	$	.....	$.....
.....	$	.....	$.....

TOTAL COST OF TICK BOXES **$ _____**

RECOMMENDED MALARIA PROPHYLAXIS / ORAL MEDS

.....

I have been informed of the following:

- The vaccines being given today
- The care after vaccination
- The risks of vaccination
- The possible side effects
- The procedure to follow in the case of an adverse event

I am satisfied that I have received enough information today explaining both the benefits and risks of the vaccines to be administered. Any questions I had have been answered to my satisfaction. I have been informed as to the immunisation.

Sheet Prepared by ..... Nurse

Sheet Prepared by ..... Doctor

Date .....

I agree to pay the full cost of the vaccines before administration.

PATIENT'S AGREEMENT SIGNATURE _____

PRINT NAME _____

DATE _____